

**DEPENDENT-ADULT PATIENT INFORMATION SHEET**

ENT & Audiology Center of Southlake

Phone: (817) 416-9731 Fax: (817) 416-9751

**PATIENT**

Date:	Patient Name: (Last, First, Middle)	DOB:	AGE:
Address:	City:	State:	Zip Code:
Home Phone:	Patient's SSN:	Sex:	
Other family members treated? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Name(s) & Relationship:			
Referred by PCP? Yes <input type="checkbox"/> No <input type="checkbox"/> Referred by Someone other than PCP? Yes <input type="checkbox"/> If Yes, Name: _____ Not Referred <input type="checkbox"/>			
PCP Name:	Phone and Fax Numbers:	City of Practice:	

**RESPONSIBLE PARTIES**

Permanent Residence is With: Father <input type="checkbox"/> Mother <input type="checkbox"/> Other <input type="checkbox"/> Name-Relationship			
Father Name: Last:	First:	Middle:	DOB:
Father's Address/Phone Same as Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If No: Father's Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	SSN:	
Employer:	Occupation:	Work Phone#	
Mother's Name: Last	First	Middle	DOB:
Address/Phone Same as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No: Mother's Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	SSN:	
Employer:	Occupation:	Emp. Phone#	

**PRIMARY INSURANCE**

Is patient a fulltime student in secondary education on parent's insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of Insurance Company:	Id/Member #:	Group#:	
Policy Holder's Name:	Policy Holder's DOB	Member/Cust. Svc. Ph #:	
Referral Required by your Insurance company? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, did you obtain one from your PCP? Yes <input type="checkbox"/> No <input type="checkbox"/>			

**SECONDARY INSURANCE**

<b>If no secondary insurance, circle: NONE</b>			
Name of Insurance Company:	Policy Holder's Name:	Policy Holder's DOB	
Id/Member #:	Group#:	Member/Cust Svc Ph #:	

I hereby authorize my physician to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to my physician for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if ENT & Audiology Center of Southlake is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physician as may be necessary in his/her judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result or cure. This form has been fully explained to me, and I certify that I understand its contents.

Signature & Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_